ELITE GYNECOLOGY, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A Notice of Privacy Practices Acknowledgement is provided to all patients and explains:

(1) how your Protected Health Information (PHI) may be used or shared;
(2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI;
(3) your rights to complain if you believe your privacy rights have been violated; and
(4) our responsibilities for maintaining the privacy of your PHI.

* I acknowledge that I have read the foregoing and received a copy of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PHI) may be used or shared.

*I authorize Elite Gynecology, LLC to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Elite Gynecology, LLC any information obtained in the adjudication of any claim for services furnished to me by Elite Gynecology, LLC.

* I acknowledge that Elite Gynecology, LLC, the physician, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.

*I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Printed Name of Patient: _____Date of Birth:_____

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Guardian: _____ Relationship to Patient: _____

FOR INTERNAL USE ONLY

_____
Employee Initials

If applicable, reason patient's written acknowledgment could not be obtained:

[ ] Patient was unable to sign. [ ] Patient refused to sign. [ ] Other:

_____

ELITE GYNECOLOGY, LLC

PATIENT COMMUNCATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals or other reasons. This is acknowledgement that you authorize Elite Gynecology, LLC and its staff to contact you and how you wish to be contacted. (Please check all that apply.)

- Cell Phone _____ [ ] ok to leave voice mail [ ] Appt Info [ ] Billing [ ] Medical
- Home Phone_____ [ ] ok to leave voice mail [ ] Appt Info [ ] Billing [ ] Medical
- Work Phone_____ [ ] ok to leave voice mail [ ] Appt Info [ ] Billing [ ] Medical
- Alternate Phone_____ [ ] ok to leave voice mail [ ] Appt Info [ ] Billing [ ] Medical
- Email:_____

I give my permission to share appointment, medical and billing information with the person names below:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name: _____Relationship: _____